TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Elite Healthcare Fort Worth

**Respondent Name**
Texas Mutual Insurance

**MFDR Tracking Number**
M4-16-3557-01

**Carrier's Austin Representative**
Box Number 54

**MFDR Date Received**
July 29, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary: July 27, 2016:** "These bills were previously submitted in a timely manner. Please review the attached documentation any pay according to the TDI guidelines."

**September 2, 2016**: Carrier did not pay for 4.20.2015. All others have been paid.

**Amount in Dispute:** $624.50

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "One year from disputed date 4/20/15 is 4/20/16. The TDI/DWC date stamp lists the received date as 7/29/16 on the requestor's DWC-60 packet, a date greater than one year from 5/20/15. The requestor has waived its right to DWC MDR. No payment is due. Texas Mutual has elected to the E&M services billed for dates 10/22/15, 11/19/15, 12/1/15, and 12/8/15."

**Response Submitted by:** Texas Mutual Insurance

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 20, 2015 | 99213 | $113.87 | |
| October 22, 2015 | 99213 | $113.87 | |
| November 19, 2015 | 99214 | $169.02 | $0.00 |
| December 1, 2015 | 99213 | $113.87 | |
| December 8, 2015 | 99213 | $113.87 | |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 790 – This charge was reimbursed in accordance to the Texas medical fee guideline
   - W3 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal
   - 138 – Appeal procedures not followed or time limits not met
   - 150 – Payer deems the information submitted does not support this level of service
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
   - 864 – E/M services may be reported only if the patient's condition requires a significant separately identifiable E/M service
   - 879 – Rule 133.250(B) – Healthcare provider shall submit the request for re consideration no later than 10 months from the date of service
   - 891 – No additional payment after reconsideration
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 217 – The value of this procedure is included in the value of another procedure performed on this date

**Issues**

1. Has the requestor waived the right to MFDR?

**Findings**

1. The requestor seeks reimbursement for CPT 99213 rendered on April 20, 2015. Requestor no longer seeks dispute on dates of service October 22, 2015, November 19, 2015, December 1, 2015, and December 8, 2015. Review of the claim line for date of service April 20, 2015 was denied for reason code 150 – "Payer deems the information submitted does not support this level of service."

   28 Texas Administrative Code §133.307 MDR(c) (1) states in pertinent part,

   > Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
   >
   > (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.
   >
   > (B) A request may be filed later than one year after the date(s) of service if:
   >
   > (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;
   >
   > (ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the insurance carrier previously denied payment based on medical necessity; or
   >
   > (iii) the dispute relates to a refund notice issued pursuant to a division audit or review, the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice.

None of the exceptions detailed above were found therefore, the timeliness requirement does apply. The date of service of April 20, 2015 would had to have been received on or before April 20, 2016 to be considered timely. The received date shown on the DWC060 is July 29, 2016. This date exceeds the one year timely filing deadline. The requestor has waived the right to MFDR. No additional payment is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

| | | |
|---|---|---|
| | | September 21, 2016 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.